

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician. Page 2 must be retained by the funeral director. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08200

08186

1. PLACE OF DEATH a. COUNTY Garrett			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland			b. COUNTY Garrett							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Oakland			c. LENGTH OF STAY IN 1b 7 yrs.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Star Route 2 Box 82			d. STREET ADDRESS Star Route 2 Box 82			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Gilbert			First Middle Last Webster Ashby			4. DATE OF DEATH Month Day Year June 14 19 67							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/27/06		9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter			10b. KIND OF BUSINESS OR INDUSTRY Building			11. BIRTHPLACE (County & State, or foreign country) Underwood, Md.			12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Seibert Ashby			14. MOTHER'S MAIDEN NAME Rebecca Strawser										
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no			16. SOCIAL SECURITY NO. 232-05-4136			17. INFORMANT Mrs. Hazel Ashby			Address see # 2 above				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <i>Cocaine of drugs with vitamins</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Chronic Rheumatoid Arthritis</i>										INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>1 yr</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Jan 5, 1967 to June 14, 1967		(County) Garrett Co.		(State) Md.		
21. I certify that (I) (this hospital) attended the deceased from June 7, 1967, to June 14, 1967, that (I) (we) last saw the deceased alive on June 7, 1967, and that death occurred at 5:00 A.M. from the causes and on the date stated above.													
22a. SIGNATURE <i>Ralph Calandrillo</i>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED						
22c. PHYSICIAN'S NAME (Type) RALPH CALANDRILLO					22d. ADDRESS Ritzmiller, MD								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 6/16/67			23c. NAME OF CEMETERY OR CREMATORY Ferndale Cemetery			23d. LOCATION (City, town or county) Garrett Co.			(State) Md.	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Gerald D. Minnich</i>					ADDRESS Oakland, Maryland		25a. REC'D BY REGISTRAR JUN 22 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

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CERTIFICATE OF DEATH

08187

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b 1 Day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Garrett County Memorial Hospital		d. STREET ADDRESS Bowery St.	
3. NAME OF DECEASED (Type or print) Fannie		4. DATE OF DEATH Month June Day 22 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 27, 86
9. AGE (In years last birthday) yrs. 80		IF UNDER 1 YEAR Months 22 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Allegany, Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John W. Blubaugh		14. MOTHER'S MAIDEN NAME Mary Alice Loar	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Carl Bechie		Address Loartown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) ischemic heart disease DUE TO (c) atherosclerosis		INTERVAL BETWEEN ONSET AND DEATH hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May , 19 67 , to June , 19 67 , that (I) (we) last saw the deceased alive on 22 Jun 19 67 , and that death occurred at 8:25 PM , from causes and on the date stated above.			
22a. SIGNATURE Dr. B. L. Grant		22b. DATE SIGNED 23 Jun 67	
22c. PHYSICIAN'S NAME (Type) Dr. B. L. Grant		22d. ADDRESS Oakland, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF June 25 1967	23c. NAME OF CEMETERY OR CREMATORY Vale Summit Meth.	23d. LOCATION (City or Town) (County) (State) Alley, Md.
24. FUNERAL DIRECTOR Marlon M. Sowers		25a. REC'D BY REGISTRAR Hafer-Sowers Funeral Home	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE JUN 28, 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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08202

CERTIFICATE OF DEATH

08188

1. PLACE OF DEATH a. COUNTY - Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b 4 days-7hrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Garrett County Memorial Hospital		d. STREET ADDRESS 11-1	
3. NAME OF DECEASED (Type or print) Bunaugh First Bunaugh Middle Lorida Last Bowser		4. DATE OF DEATH Month June Day 27 , Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 14, 1914--55 yrs.
9. AGE (In years lost birthday) 53 yrs.		10. IF UNDER 1 YEAR Months 11 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife Prop.		10b. KIND OF BUSINESS OR INDUSTRY Nursing home	
11. BIRTHPLACE (County & State, or foreign country) Garrett Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles Hart		14. MOTHER'S MAIDEN NAME Sarah Wilson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-32-4537	
17. INFORMANT Gorman Bowser, Deer Park, Md.		Address (Husband)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic sarcoma 1810 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) sarcoma of lumbar bladder DUE TO (c) 3md			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Apr , 19 67 , to Jun , 19 67 , that (I) (we) last saw the deceased alive on June 26 , 19 67 , and that death occurred at 12:58 AM causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED 27-June 67	
22c. PHYSICIAN'S NAME (Type) Dr. B. L. Grant		22d. ADDRESS Oakland, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF June 29, 67	23c. NAME OF CEMETERY OR CREMATORY Deer Park Cemetery	23d. LOCATION (City or Town) (County) (State) Deer Park, Garr., Md.
24. FUNERAL DIRECTOR John O. Durst		25a. REC'D BY REGISTRAR John O. Durst	
25b. REGISTRAR'S SIGNATURE [Signature]		DATE JUN 30 1967	

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Dr. J. L. Grant

Estimated, Maryland

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08203

CERTIFICATE OF DEATH

08189

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Garrett</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Grantsville (Rural)</u>				c. LENGTH OF STAY in lb <u>Life</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>Grantsville (Rural)</u>			
3. NAME OF DECEASED (Type or print) First <u>HENRY</u> Middle <u>---</u> Last <u>GEORG</u>				4. DATE OF DEATH Month <u>June</u> Day <u>1</u> Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>Jan. 14, 1884</u>		9. AGE (In years last birthday) yrs. <u>83</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>19</u> Min. <u>67</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Keyzers Ridge, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Georg</u>				14. MOTHER'S MAIDEN NAME <u>Savilla Deihl</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-56-7798</u>		17. INFORMANT <u>Ray Georg, Grantsville, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> DUE TO (b) <u>Heart disease, arteriosclerotic</u> DUE TO (c) <u>Senile degenerative changes</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>mental retardation congenital</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5-24</u> , 19 <u>67</u> , to <u>6-1-</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5-24</u> , 19 <u>67</u> , and that death occurred at <u>3:15</u> P.M., from causes and on the date stated above.							
22a. SIGNATURE <u>Grant Atwell</u>				22b. DATE SIGNED <u>6-3-67</u>		22c. PHYSICIAN'S NAME (Type) <u>Grant ATWELL</u>	
22d. ADDRESS <u>Meyersdale, Pa.</u>				22e. REC'D BY REGISTRAR <u>Charles Judge</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/4/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Paul's Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Accident, Garrett, Md.</u>	
24. FUNERAL DIRECTOR <u>Ruth Newman</u>				25a. ADDRESS <u>Grantsville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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08204

CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b 1 1/2 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Oak Rest Nursing Home		d. STREET ADDRESS Kitzmiller	
3. NAME OF DECEASED (Type or print) First MARY Middle Geneva Last HARVEY		4. DATE OF DEATH Month June Day 2 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 3, 1873
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		9b. KIND OF BUSINESS OR INDUSTRY Own Home	9c. AGE (In years last birthday) yrs. 93
11. BIRTHPLACE (County & State, or foreign country) Westernport, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert E. Wilson		14. MOTHER'S MAIDEN NAME Sarah Webb	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-52-9827	
17. INFORMANT S. 8th Street		Mrs. Viola Davy, Oakland, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO (b) Generalized arteriosclerosis DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH 48
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July , 19 66 , to June 2 , 19 67 that (I) (we) last saw the deceased alive on June 1 , 19 67 , and that death occurred at 4 p.m. from causes and on the date stated above.			
22a. SIGNATURE B. L. Grant, M.D.		22b. DATE SIGNED June 3, 1967	
22c. PHYSICIAN'S NAME (Type) B. L. Grant, M.D.		22d. ADDRESS Oakland, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF June 5/67	23c. NAME OF CEMETERY OR CREMATORY I.D.O.F. Cemetery	23d. LOCATION (City or Town) (County) (State) Elk Garden, Mineral Co. W.Va
24. FUNERAL DIRECTOR Amy Mildred Shepley		25a. REC'D BY REGISTRAR JUN 7 1967	
25b. REGISTRAR'S SIGNATURE [Signature]			

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08205

CERTIFICATE OF DEATH

08191

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND			c. LENGTH OF STAY IN 1b 40 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MT. LAKE PARK,		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GARRETT COUNTY MEMORIAL HOSPITAL				d. STREET ADDRESS 506 I STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARTHA ANN LAWTON				4. DATE OF DEATH JUNE 10, 1967 19			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/7/06		9. AGE (In years last birthday) 59 60 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Public School		10b. KIND OF BUSINESS OR INDUSTRY TEACHER		11. BIRTHPLACE (County & State, or foreign country) Preston Co., W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME OBED HAMPSTEAD				14. MOTHER'S MAIDEN NAME ANNA FIKE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-38-5994		17. INFORMANT H* PERCY LEE LAWTON-506 I STREET, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fibro-sarcoma, scalp 1914 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO 11-6-62						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov. 6, 1962 to JUNE 10, 1967 , that (I) (we) last saw the deceased alive on JUNE 10, 1967 , and that death occurred at 5:20 P.M. from causes and on the date stated above.							
22a. SIGNATURE J. Alvarez M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6/12/67	
22c. PHYSICIAN'S NAME (Type) DR. JOSEPH ALVAREZ				22d. ADDRESS OAKLAND, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 13, 67		23c. NAME OF CEMETERY OR CREMATORY Garr. Co. Memorial Gar.		23d. LOCATION (City or Town) (County) (State) Oakland, Maryland	
24. FUNERAL DIRECTOR John O. Durst				25a. REC'D BY REGISTRAR John O. Durst		25b. REGISTRAR'S SIGNATURE Charles Judge	
Leighton-Durst Funeral Home, Oakland, Md.				JUN 14 1967			

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08206

CERTIFICATE OF DEATH

08192

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Pennsylvania b. COUNTY Fayette	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b 2 Days 11½ Hr.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brownsville 75-3
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Garrett County Memorial Hospital		d. STREET ADDRESS 16-Elm Street	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Irene Marker League		4. DATE OF DEATH Month Day Year June 4, 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 7-13-99
9. AGE (In years lost birthday) 67 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (County & State, or foreign country) Brownsville, Pa.
12. CITIZEN OF WHAT COUNTRY? America		13. FATHER'S NAME Frank J. Marker	
14. MOTHER'S MAIDEN NAME Nancy Coulter		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16. SOCIAL SECURITY NO. - - -		17. INFORMANT William League see # 2 above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic disease DUE TO (c) Arteriosclerotic disease			INTERVAL BETWEEN ONSET AND DEATH day Yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July , 19 66 , to June 4, 1967 , that (I) (we) last saw the deceased alive on June 4, 1967 , and that death occurred at 7:32 A.M. from causes and on the date stated above.			
22a. SIGNATURE B. L. Grant		22b. DATE SIGNED 5 Jun 67	
22c. PHYSICIAN'S NAME (Type) Dr. B. L. Grant		22d. ADDRESS Oakland, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6/7/67	23c. NAME OF CEMETERY OR CREMATORY Lafayette Mem. Park	23d. LOCATION (City or Town) (County) (State) Brownsville, Penna.
24. FUNERAL DIRECTOR Charles D. Minnich		25a. REC'D BY REGISTRAR JUN 12 1967 DATE	
25b. REGISTRAR'S SIGNATURE Charles Judge			

10189

CERTIFICATE OF DEATH

08386



Name of Deceased		Age		Sex		Race		Marital Status		Date of Death		Place of Death		Cause of Death		Signature of Physician		Signature of Registrar	
John Doe		45		Male		White		Married		Jan 15, 1950		New York City		Heart Disease		[Signature]		[Signature]	
Occupation		Education		Religion		Birth Date		Birth Place		Date of Burial		Place of Burial		Funeral Home		Burial Date		Burial Place	
Teacher		High School		Catholic		Jan 1, 1905		New York City		Jan 20, 1950		New York City		St. John's		Jan 20, 1950		New York City	
Manner of Death		Time of Death		Weather		Time of Day		Month of Year		Day of Week		Year		Decade		Century		Millennium	
Natural		10:30 AM		Clear		10:30 AM		January		Friday		1950		1950s		20th		21st	
Disease		Organ		System		Tissue		Cell		Molecule		Atom		Particle		Quark		Lepton	
Myocardial Infarction		Heart		Circulatory		Cardiac		Myocardium		Cell		Molecule		Atom		Particle		Quark	
Coronary Artery Disease		Artery		Vascular		Blood Vessel		Capillary		Molecule		Atom		Particle		Quark		Lepton	
Atherosclerosis		Plaque		Fibrous		Lipid		Cholesterol		Molecule		Atom		Particle		Quark		Lepton	
Hypertension		Blood Pressure		Hemodynamic		Flow		Resistance		Molecule		Atom		Particle		Quark		Lepton	
Diabetes Mellitus		Insulin		Metabolic		Glucose		Hemoglobin		Molecule		Atom		Particle		Quark		Lepton	
Obesity		Weight		Body Mass Index		BMI		Waist Circumference		Molecule		Atom		Particle		Quark		Lepton	
Smoking		Tobacco		Nicotine		Tar		Carcinogens		Molecule		Atom		Particle		Quark		Lepton	
Alcohol Consumption		Ethanol		Liver		Gallbladder		Pancreas		Molecule		Atom		Particle		Quark		Lepton	
Trauma		Injury		Fracture		Dislocation		Contusion		Molecule		Atom		Particle		Quark		Lepton	
Infection		Bacteria		Virus		Fungus		Parasite		Molecule		Atom		Particle		Quark		Lepton	
Septicemia		Sepsis		Shock		Organ Failure		Multi-Organ Dysfunction		Molecule		Atom		Particle		Quark		Lepton	
Respiratory Failure		Lungs		Pneumonia		Asthma		COPD		Molecule		Atom		Particle		Quark		Lepton	
Cardiac Arrest		Heart		Circulatory		Blood Flow		Electrical Activity		Molecule		Atom		Particle		Quark		Lepton	
Sudden Death		Unexplained		Mystery		Mystery		Mystery		Molecule		Atom		Particle		Quark		Lepton	
Suicide		Self-Harm		Mental Health		Depression		Anxiety		Molecule		Atom		Particle		Quark		Lepton	
Homicide		Murder		Violence		Aggression		Conflict		Molecule		Atom		Particle		Quark		Lepton	
Execution		Capital Punishment		Death Row		Gallows		Firing Squad		Molecule		Atom		Particle		Quark		Lepton	
War		Conflict		Battle		War		War		Molecule		Atom		Particle		Quark		Lepton	
Natural Disaster		Earthquake		Flood		Hurricane		Tornado		Molecule		Atom		Particle		Quark		Lepton	
Pollution		Air Quality		Water Quality		Soil Quality		Noise		Molecule		Atom		Particle		Quark		Lepton	
Climate Change		Global Warming		Sea Level Rise		Extreme Weather		Drought		Molecule		Atom		Particle		Quark		Lepton	
Nuclear War		Nuclear Energy		Nuclear Power		Nuclear Weapons		Nuclear Accidents		Molecule		Atom		Particle		Quark		Lepton	
Space Exploration		Outer Space		Cosmos		Galaxies		Planets		Molecule		Atom		Particle		Quark		Lepton	
Artificial Intelligence		Machine Learning		Deep Learning		Neural Networks		Computer Vision		Molecule		Atom		Particle		Quark		Lepton	
Biotechnology		Genetics		Molecular Biology		Cell Biology		Biochemistry		Molecule		Atom		Particle		Quark		Lepton	
Nanotechnology		Nanoparticles		Nanomaterials		Nanodevices		Nanomedicine		Molecule		Atom		Particle		Quark		Lepton	
Quantum Computing		Quantum Mechanics		Quantum Theory		Quantum Entanglement		Quantum Superposition		Molecule		Atom		Particle		Quark		Lepton	
Space Exploration		Outer Space		Cosmos		Galaxies		Planets		Molecule		Atom		Particle		Quark		Lepton	
Artificial Intelligence		Machine Learning		Deep Learning		Neural Networks		Computer Vision		Molecule		Atom		Particle		Quark		Lepton	
Biotechnology		Genetics		Molecular Biology		Cell Biology		Biochemistry		Molecule		Atom		Particle		Quark		Lepton	
Nanotechnology		Nanoparticles		Nanomaterials		Nanodevices		Nanomedicine		Molecule		Atom		Particle		Quark		Lepton	
Quantum Computing		Quantum Mechanics		Quantum Theory		Quantum Entanglement		Quantum Superposition		Molecule		Atom		Particle		Quark		Lepton	

THIS CERTIFICATE IS VALID FOR THE PURPOSE OF RECORDING AND FOR THE PURPOSE OF ISSUING A DEED OF CONVEYANCE ONLY. IT IS NOT VALID FOR THE PURPOSE OF ISSUING A DEED OF CONVEYANCE FOR THE PURPOSE OF RECORDING.

1
FOR STATE HEALTH DEPT. **M**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any person is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

08207

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08193

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Deer Park				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ruarl - Deer Park			
c. LENGTH OF STAY IN lb Lifetime				d. STREET ADDRESS Route #1			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Route #1				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ELIA		First TRUTH		Last MOON		4. DATE OF DEATH Month June Day 11 , Year 1967	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 19, 1880	
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months 86 Days 86		IF UNDER 24 HRS. Hours 86 Min. 86			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Garrett Co., Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Sebastian Hinebaugh				14. MOTHER'S MAIDEN NAME Emily Tower Harvey			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give year or dates of service)				16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Hilda Madigan, Deer Park, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO Arteriosclerosis, generalized Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH 36 hrs. Years			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 6/12/67			
ACTUAL SIGNATURE James H. Feaster, Jr., M.D.				Address (Street, city, town, or county) Oakland, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/13/67		22c. NAME OF CEMETERY OR CREMATORY Deer Park Cemetery		22d. LOCATION (City, town, or country) (State) Deer Park, Maryland	
23. FUNERAL DIRECTOR John O. Durst				24. REGISTRAR'S SIGNATURE Charles J. J...			
Leighton-Durst Funeral Home, Oakland, Md.				JUN 14 1967			

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08208

08194

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Kentucky b. COUNTY Boyd			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bloomington		c. LENGTH OF STAY IN tb Minutes		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ashland 55.3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS 4023 Washington Ave.			
3. NAME OF DECEASED (Type or print) Thomas Richendollar				4. DATE OF DEATH Month June Day 18 Year 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 21, 1937	9. AGE (In years birth day) yrs. 29	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Trucking		11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Homer Richendollar				14. MOTHER'S MAIDEN NAME Irene Blevins			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown		16. SOCIAL SECURITY NO. 407 48 2910		17. INFORMANT Address Patricia Richendollar, Ashland, Ky			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushed Chest; Crushed Face 8161 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (Driver of Truck involved in Accident) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH Minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Operating truck which wrecked and collided with car. Rt.135					
20c. TIME OF INJURY Month, Day, Year Hour o.m. 9:20 AM 6-18 '67		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) (County) (State) Bloomington Garrett Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James H. Feaster, Jr., M. D.				22. DATE SIGNED Oakland, Md. 6-18-67			
23a. BURIAL, CREMATION, or other disposal (Specify) Burial		23b. DATE THEREOF 6/21/67		23c. NAME OF CEMETERY OR CREMATORY E. Ashland Mem. Gardens		23d. LOCATION (City or Town) (County) (State) Ashland Boyd Ky.	
24. FUNERAL DIRECTOR E.S. Boal Westernport, Md.				25a. REC'D BY REGISTRAR JUN 20 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08209

08195

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE West Virginia b. COUNTY Mineral	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bloomington		c. LENGTH OF STAY IN lb Minutes	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle Edward Last Riley, Jr.		4. DATE OF DEATH Month June Day 18th. Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Febr. 5, 1958
9. AGE (In years last birthday) 9 yrs.		10. IF UNDER 1 YEAR Months 18 Days 18 Hours 18 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY elementary school	
11. BIRTHPLACE (State or foreign country) Keyser, W.Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Riley		14. MOTHER'S MAIDEN NAME Nellie Marie Hoover	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) -		16. SOCIAL SECURITY NO. -	
17. INFORMANT George Riley, 134 W. Fairview, Piedmont		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushed Skull DUE TO (Passenger in auto struck by truck) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 8161 (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in auto which was struck by truck. Rt. 135	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 9:20 6-18-67		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work Highway	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Bloomington Garrett Md.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James H. Feaster, Jr., M.D.		22. DATE SIGNED Oakland, Md. 6-18-67	
EXAMINER'S NAME (Type) James H. Feaster, Jr., M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 21, 1967	
23c. NAME OF CEMETERY OR CREMATORY potomac Valley Mem. Gard.		23d. LOCATION (City or Town) (County) (State) Keyser, Mineral, W.Va.	
24. FUNERAL DIRECTOR E. S. Boal, Westernport, Md.		25a. REC'D BY REGISTRAR JUN 20 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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1994

1992

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08210

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08196

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE West Virginia b. COUNTY Mineral	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bloomington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural—Piedmont, West Virginia	
c. LENGTH OF STAY IN 1b Minutes		d. STREET ADDRESS Mailing address. Route 4, Keyser, W.Va.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Janet Yvonne Riley		4. DATE OF DEATH Month Day Year June 18th 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 16, 1939
9. AGE (In years lost birthday) 28 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 18th 19 67	
10a. USUAL OCCUPATION (Give kind of work done or kind of business or profession if retired) School teacher		10b. KIND OF BUSINESS OR INDUSTRY Mineral County	
11. BIRTHPLACE (State or foreign country) Hampshire, W.Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George E. Riley		14. MOTHER'S MAIDEN NAME Mary Irene Daugherty	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 232-60-5054	
17. INFORMANT George E. Riley, Rt. 4, Keyser, W.Va.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured Skull; Fractured neck DUE TO (b) (Auto Accident—Driver) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 8/6/			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Operator of vehicle which was struck by truck. Rt. 135	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 9:20 PM 6-18-67		20d. INJURY OCCURRED <input checked="" type="checkbox"/> While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway	
20f. (City or town) Bloomington Garrett, Md.		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i>		22. DATE SIGNED June 18, 1967	
EXAMINER'S NAME (Type) James H. Feaster, Jr., M. D.		Address (Street, city, town, or county) Oakland, Md. 6-18-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 21, 1967	
23c. NAME OF CEMETERY OR CREMATORY Potomac Valley Mem. Cnd.		23d. LOCATION (City or Town) (County) (State) Keyser, Mineral, W.Va.	
24. FUNERAL DIRECTOR <i>E.S. Boal</i> E.S. Boal, Westernport, Md.		25a. REG. BY REGISTRAR June 20 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

08211

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #7 Film #G390 6/26/67 pc

CERTIFICATE OF DEATH

08197

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. LENGTH OF STAY IN 1b 17 HRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GARRETT COUNTY MEMORIAL HOSPITAL			d. STREET ADDRESS STAR ROUTE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last AMBROSE FREDLOCK SCHENK			4. DATE OF DEATH Month Day Year JUNE 10, 19 67		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 1885 FEBRUARY 3, 1885		9. AGE (In years last birthday) yrs. 82
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY FARMER		11. BIRTHPLACE (County & State, or foreign country) GARRETT, MARYLAND	
13. FATHER'S NAME Namond Schenk			14. MOTHER'S MAIDEN NAME Emma Fredlock		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 218-12-5453-4		17. INFORMANT Address W-LOIS SCHENK-STAR ROUTE, OAKLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4500 Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Sclerosis DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 3 days years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 1965 , to JUNE 10, 1967 , that (I) (we) last saw the deceased alive on JUNE 10, 1967 , and that death occurred at 8:06 P.M. from causes and on the date stated above.					
22a. SIGNATURE A. E. Mance			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10 June 67
22c. PHYSICIAN'S NAME (Type) DR. A. E. MANCE			22d. ADDRESS OAKLAND, MARYLAND		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/13/67		23c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery	
23d. LOCATION (City or Town) (County) (State) Oakland Maryland					
24. FUNERAL DIRECTOR Gerald D. Minnich			ADDRESS Oakland, Maryland		25a. REC'D BY REGISTRAR JUN 20 1967
			25b. REGISTRAR'S SIGNATURE Charles Judge		

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08212

08198

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Lake Park				c. LENGTH OF STAY IN lb 20 yrs.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 310 "E" Street				d. STREET ADDRESS 310 "E" Street			
3. NAME OF DECEASED (Type or print) EARL JOSEPH SEBOLD				4. DATE OF DEATH Month June Day 23 Year 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 21, 1911	
9. AGE (In years last birthday) yrs. 56		IF UNDER 1 YEAR Months 5 Days 11 Hours 11 Min.		IF UNDER 24 HRS. Hours 11 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor				10b. KIND OF BUSINESS OR INDUSTRY Road Building		11. BIRTHPLACE (State or foreign country) Garrett Co., Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Joseph F. Sebold				14. MOTHER'S MAIDEN NAME Elizabeth McGettigan			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 219-14-5953		17. INFORMANT Lena Sebold, Mt. Lake Park, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon monoxide poisoning DUE TO (b) 9731 DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH Minutes			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Ran motor of car in closed garage while in back seat.			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 10 xx 6-23-67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Residence		20f. (City or town) (County) (State) Mt. Lake Park Garrett Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i> M.D.				22. DATE SIGNED 6-23-67			
EXAMINER'S NAME (Type) James H. Feaster, Jr., M. D.				Address (Street, city, town, or county) Oakland, Garr. Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/26/67		23c. NAME OF CEMETERY OR CREMATORY Garr. Co. Memorial Gard.		23d. LOCATION (City or Town) (County) (State) Oakland, Maryland	
24. FUNERAL DIRECTOR John O. Durst				25a. REC'D BY REGISTRAR Charles Judge			
Address Leighton-Durst Funeral Home, Oakland, Md.				25b. REGISTRAR'S SIGNATURE Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08199

08213

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN Tb 3Days 13 Hr.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Garrett County Memorial Hospital		d. STREET ADDRESS Rt. 1, Box 405	
3. NAME OF DECEASED (Type or print) First Mary Middle Elizabeth Last Sines		4. DATE OF DEATH Month June Day 20 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-9-02
9. AGE (In years lost birthday) 65 yrs.		IF UNDER 1 YEAR Months 6 Days 13 Hours 13 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Oakland, Maryland		12. CITIZEN OF WHAT COUNTRY? America	
13. FATHER'S NAME Adolphus William Kimmell		14. MOTHER'S MAIDEN NAME Effie Roxanna Welch	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 218-12-5453	
17. INFORMANT Clyde C. Sines		Address see # 2 above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic carcinoma DUE TO (b) carcinoma of pancreas DUE TO (c) unk. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Apr 20 , 19 63 , to June 20, 1967 , that (I) (we) lost the deceased on June 20 1967 , and that death occurred at 1:00A.M. , from causes and on the date stated above.			
22a. SIGNATURE B. L. Grant		22b. DATE SIGNED 20 June 67	
22c. PHYSICIAN'S NAME (Type) Dr. B. L. Grant		22d. ADDRESS Oakland, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6/22/67	23c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery	23d. LOCATION (City or Town) (County) (State) Oakland Maryland
24. FUNERAL DIRECTOR Gerald N. Minnich		25a. REG'D BY REGISTRAR JUN 26 1967	
25b. REGISTRAR'S SIGNATURE [Signature]			

VR A15 (4)
20 M 1/66

5156

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

08214

CERTIFICATE OF DEATH

08200

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kitzmiller c. LENGTH OF STAY IN 1b 13Yrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Main Street				2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence (Commission)) e. STATE Maryland b. COUNTY Garrett c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kitzmiller d. STREET ADDRESS Main Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First George Middle William T. Last Stewart		4. DATE OF DEATH Month June Day 8 Year 1967					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 21, 1903	9. AGE (In years last birthday) 63 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Mines		11. BIRTHPLACE (County & State, or foreign country) Garrett Co., Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Lemuel George W. Stewart			14. MOTHER'S MAIDEN NAME Rosetta Margaret Harvey				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or, unknown) No		16. SOCIAL SECURITY NO. 233-16-5058		17. INFORMANT Address Gladys Stewart, Kitzmiller, Md. 21538			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO (b) Coronary Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)					INTERVAL BETWEEN ONSET AND DEATH 1 yr		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Diabetes Mellitus							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from June 5, 1967, to June 8, 1967, that (I) (we) last saw the deceased alive on June 5, 1967, and that death occurred at 3:40 A.M. from the causes and on the date stated above.							
22e. SIGNATURE Ralph Calandrella		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Kitzmiller, Md. 21538		22b. DATE SIGNED June 8-67			
22c. PHYSICIAN'S NAME (Type) DR. Ralph Calandrella, M.D.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 67		23c. NAME OF CEMETERY OR CREMATORY I.O.O.F. Cemetery			
23d. LOCATION (City, town or county) (State) Elk Garden, Mineral Co. Va.							
24. FUNERAL DIRECTOR'S SIGNATURE Amy Mildred Sharples		25a. REC'D BY REGISTRAR JUN 12 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08314

CERTIFICATE OF DEATH

DATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

PLACE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

CAUSE OF DEATH

George William T. Stewart

White Male, Age 63, Dec. 21, 1903

George W. Stewart, U.S.A.

George W. Stewart, U.S.A.

George W. Stewart, U.S.A.

George W. Stewart, U.S.A.

George W. Stewart, U.S.A.

George W. Stewart, U.S.A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08215

08201

1. PLACE OF DEATH e. COUNTY Garrett b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bloomington d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Garrett c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bloomington d. STREET ADDRESS Bloomington a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Minnie First Tibbetts Middle June Last 1967		4. DATE OF DEATH Month June Day 28 Year 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1865 Aug. 14, 1865	9. AGE (In years last birthday) 101 yrs. IF UNDER 1 YEAR Months Days Hours Min.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (County & State, or foreign country) Somerset Pa.	
13. FATHER'S NAME Hiram Penrod		14. MOTHER'S MAIDEN NAME Annie Boyts		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no	
16. SOCIAL SECURITY NO.		17. INFORMANT Laura T. Kelly Address Bloomington, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized arteriosclerosis 4500 DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 20 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from....., 19.46 to....., 19.46 that (I) (we) last saw the deceased alive on....., 19.46, and that death occurred at....., 19.46, from the causes and on the date stated above.					
22a. SIGNATURE James H. Wolverson Jr M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. James H. Wolverson Jr		22d. ADDRESS Piedmont, W.Va.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/1/67		23c. NAME OF CEMETERY OR CREMATORY Bloomington Cemetery	
23d. LOCATION (City, town or county) Bloomington		23e. (State) Md.			
24. FUNERAL DIRECTOR'S SIGNATURE W. N. H. Hook Jr		ADDRESS Piedmont, W.Va.		25a. REC'D BY REGISTRAR JUL 6 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge					

08215

08201

Bloomington

Bloomington

Direct

Maryland

Miss

Miss

Female

White

X

Aug. 14, 1944 - 101

House-wife

own home

married 14.

U.S.A.

Miss

Miss

no

Miss

Bloomington, Md.

Mr. James H. Wolferton Jr. Richmond, W. Va.

Wife

Bloomington Cemetery, Bloomington, Md.

Richmond, W. Va.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08216

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08202

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b Minutes		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Oakland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) (DOA) Garrett Co. Memorial Hospital			d. STREET ADDRESS Rt. 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Truman Edward Uphold			4. DATE OF DEATH Month Day Year June 16th. 1967		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 10, 1929	9. AGE (In years last birthday) yrs. 37	IF UNDER 1 Year Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mason		10b. KIND OF BUSINESS OR INDUSTRY Masonry		11. BIRTHPLACE (State or foreign country) Oakland, Maryland	
13. FATHER'S NAME Jasper Uphold			14. MOTHER'S MAIDEN NAME Laura Uphold		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1951		16. SOCIAL SECURITY NO.		17. INFORMANT Naomi Uphold. See #2 above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Allergic shock DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Multiple Bee Stings DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH Minutes Minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pulmonary emphysema					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Stung by bees			
20c. TIME OF INJURY Month, Day, Year Hour 11:30 6-15-67 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home (Rural) Oakland Garrett Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i>		EXAMINER'S NAME (Type) James H. Feaster, Jr., M. D.		22. DATE SIGNED Oakland, Md. 6-16-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/18/67		23c. NAME OF CEMETERY OR CREMATORY Wolfe Cemetery	
24. FUNERAL DIRECTOR Gerald D. Minnich		ADDRESS Oakland, Maryland		25. ACC'D BY REGISTRAR JUN 20 1967	
				26. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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08217

CERTIFICATE OF DEATH

08203

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Garrett b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Lake Park		c. LENGTH OF STAY IN lb 8 yrs.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Lake Park	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 418 Maple Avenue,		d. STREET ADDRESS 418 Maple Avenue,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First IDA Middle CATHERINE Last WALTERS		4. DATE OF DEATH Month June Day 23 Year 19 67			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 12, 1887	9. AGE (In years last birthday) yrs. 80	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (County & State, or foreign country) Garrett Co., Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Sampson Bittinger		14. MOTHER'S MAIDEN NAME Barbara Engle	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address (Dau.) Mrs. Bertha Harvey, Mt. Lake Park, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis DUE TO (b) Arteriosclerotic Cardio-Renal Dis- DUE TO (c) Arteriosclerosis					INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 10 to June 24 , 19 67 , that (I) (we) last saw the deceased alive on June 10 19 67 , and that death occurred at 4:20 M, from causes and on the date stated above.					
22a. SIGNATURE Andrew E. Mance		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED June 24, 1967	
22c. PHYSICIAN'S NAME (Type) Andrew E. Mance, M.D.		22d. ADDRESS Oakland, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6/25/67	23c. NAME OF CEMETERY OR CREMATORY Pope Cemetery	23d. LOCATION (City or Town) (County) (State) Near Gorman, W. Va.		
24. FUNERAL DIRECTOR John O. Durst		25a. REC'D BY REGISTRAR John O. Durst		25b. REGISTRAR'S SIGNATURE Charles Judge	
Leighton-Durst Funeral Home, Oakland, Md.		DATE JUN 26 1967			

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• *Chlorophyll*

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CERTIFICATE OF DEATH

08205

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
c. LENGTH OF STAY IN lb. 3Hrs 30 Min.		Mt. Lake Park, Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Garrett Co. Memorial Hospital		d. STREET ADDRESS 911 Broadford Road	
3. NAME OF DECEASED (Type or print) First Bertha Middle Alice Last Weimer		4. DATE OF DEATH Month June Day 7 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 7, 1882
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months 8 Days 5	IF UNDER 24 HRS. Hours 8 Min. 5
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeping		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (County & State, or foreign country) Garrett Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Jessie Weimer		14. MOTHER'S MAIDEN NAME Elizabeth Friend	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) diabetes mellitus		19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 65 , to June 7, 19 67 , that (I) (we) last saw the deceased alive on Jun 6 19 67 , and that death occurred at 12:35 PM , from causes and on the date stated above.			
22a. SIGNATURE B. L. Grant		22b. DATE SIGNED 8 Jun 67	
22c. PHYSICIAN'S NAME (Type) Dr. B. L. Grant		22d. ADDRESS Oakland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/10/67	
23c. NAME OF CEMETERY OR CREMATORY Ferndale Cem.		23d. LOCATION (City or Town) (County) (State) Near Oakland, Md.	
24. FUNERAL DIRECTOR John O. Durst Leighton-Durst Funeral Home, Oakland, Md.		25a. REC'D BY REGISTRAR Charles Judge DATE JUN 12 1967	
25b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08218

08202

STATE OF OHIO

IN SENATE

January 1, 1902

REPORT

OF THE

COMMISSIONER OF THE

LAND OFFICE

FOR THE YEAR

1901

AND

THE

LANDS

UNDER

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ACT

OF

APRIL 1, 1901

AND